Protecting Children: Substance Abuse and Child Welfare Working Together
State-Team Building Workshop
Chandler, Arizona
May 22-23, 2001

INTRODUCTION AND PURPOSE

The Division of State and Community Assistance of the Center for Substance Abuse Treatment (CSAT), in conjunction with the Administration on Children, Youth and Families (ACYF), held a two-day state team-building workshop May 22 and 23, 2001, in Chandler, Arizona. The workshop was titled, *Protecting Children: Substance Abuse and Child Welfare Working Together*. This was the second of four CSAT/ACYF meetings to be held on this topic in 2001. These workshops are designed to help build the state infrastructure necessary to bring about coordinated delivery of care for children in the child welfare system and their parents in substance abuse treatment.

The federal sponsors invited states to send teams of six individuals representing single state alcohol and other drug agencies, state child welfare agencies, members of the judiciary, and other agencies and individuals involved with families, including foster care, TANF, Medicaid, advocacy groups, and consumers. Team members completed a Collaborative Values Inventory prior to attending the workshop, which was designed to help them start thinking about the values and principles they share and those on which they need work to reach consensus.

In addition to their work in values clarification and state team building, workshop attendees heard presentations on such topics as the Adoption and Safe Families Act (ASFA), family drug courts, and successful approaches to collaborative work. They attended concurrent working sessions on confidentiality, interdisciplinary training, substance abuse assessments, trauma, working with the courts, and addressing the needs of both parents and children in child protective services. The agenda for this workshop evolved from a national planning meeting held in Bethesda, MD, in November 2000.

Tuesday, May 22

WELCOME

H Richard (Rick) Sampson, Director
Division of State and Community Assistance
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration

This is the second in a series of meetings that we are co-hosting with our colleagues from the Administration on Children, Youth and Families around collaborative issues and team building related to substance abuse treatment and child welfare.

The purpose of this meeting is to bring together state substance abuse agencies and state child welfare agencies to discuss our interdependent and shared missions of providing high quality services to families in need of both child welfare and substance abuse services. The passage of the Adoption and Safe Families Act was a precipitating factor in our efforts to work together. This legislation reminds us that children's safety is a paramount issue for all of us, not just child welfare agencies, and that children need to be placed in safe family environments. We also need to keep in mind the importance of prevention when working with children; not only substance abuse prevention, but prevention of all family dysfunction that confounds the problems presented to our agencies.

We need to discuss our shared values and address the trauma that exists among the families we treat. Our experiences in service delivery show that we often serve the same child, the same parent, and the same family in both of our systems. We need each other to do this work well. We often look at these problems from different points of view. By joining together to engage in collaboration and team building, we are presented with the opportunity and the responsibility to be healers for this generation and for generations to come. It is this that brings us together today.

Feedback from participants is welcome. We have developed this workshop agenda with your input and will use your comments to help shape our future regional workshops.

Catherine M. Nolan, M.S.W., A.C.S.W., Director
Office of Child Abuse and Neglect
Children's Bureau
Administration on Children, Youth and Families
Administration for Children and Families

In order to understand why we are here today, it is important to place these issues in the context of our historical development. Our office is the federal contact point for child welfare within the Children's Bureau of the Administration on Children, Youth and Families, Department of Health and Human Services. The Children's Bureau has been in existence since 1913, when we addressed such issues as orphan trains.

In 1999 Congress passed the Adoption and Safe Families Act (ASFA, P.L. 105-89). This was the first major piece of child welfare legislation in recent history. The Act required a report to Congress on the issues of child protective services and substance abuse treatment. Published April 1, 1999, the report is titled, *Blending Perspectives and Building Common Ground*. The report is a collaborative effort that discusses the problems that existed between the two systems, examines what was working and what was not working, and makes recommendations for the future. The report also recommends specific actions that federal agencies, state governments, and local communities should take to address this problem.

This group represents both child welfare agencies and substance abuse agencies at all three levels of government and also includes a very important perspective from courts that deal with

both the alcohol and drug abuse issues and child welfare issues. Many of the attendees may not have been together in the same room discussing this issue before today.

The number one recommendation in the report to Congress is to build collaborative working relationships between the child welfare and substance abuse treatment systems. Partnerships are essential; no single effort is adequate. Ongoing interdisciplinary training is required to build successful relationships between agencies, as is training in effective parenting and family support. Cross-training is a powerful vehicle to share common skills and knowledge, and together, CSAT and ACYF have allocated resources to accomplish this goal.

This meeting is part of a nationwide effort to accomplish the goals and recommendations of the report to Congress. We sincerely hope that this effort will make a difference. Our challenge is to think about the tensions and the issues that have been raised in the report, and to look to our state colleagues to examine these issues and the steps necessary to resolve them. We look forward to a very productive workshop.

Christina Dye, Chief
Mental Health and Substance Abuse Treatment and Prevention
Arizona Department of Human Services

Welcome to Arizona. We are honored to host this two-day meeting about substance abuse and child welfare services. Arizona is in the second year of developing Team Care Partnerships to offer focused treatment for parents and families who have had children removed from the home because of abuse and neglect. Our team partnerships work because we have a commitment to share clients, keep our sense of humor, and maintain a vision that by working together, we can provide better services than we could by working independently. We will share our accomplishments with you over the next two days.

GENERAL SESSIONS

Adoption and Safe Families Act: Foundations for Collaboration

H Richard (Rick) Sampson

It is necessary to understand the context of the meeting as it relates to the need for alcohol and drug abuse treatment and prevention and why these realities present a challenge to all of us. The need for services continually changes. For example, many states indicate an increase in methamphetamine use in the last few years. With our continued concerns for child safety, we are finding a new spectrum of problems has emerged. For example, children who live in and around methamphetamine labs are exposed to toxic substances. As a result, many police who conduct drug raids now carry children's clothing with them. The mobility of these labs is also a concern.

There also are concerns about the nature of methamphetamine use as it relates to treatment. We often assume that a person who starts taking a drug continues to maintain the choice to stop. This is not necessarily true with methamphetamine. Persons who take these drugs may lose their ability to choose. The nature of addiction and pain avoidance present unique treatment challenges, and we have concerns about the time it takes for the body to heal and the brain to restructure. Physiological healing is necessary for effective recovery to take place. It takes longer to engage a person in treatment, and the treatment itself takes longer, as well.

We continue to gather information about the nature of addiction. For example, we now know that 85 percent of the women coming into treatment have been physically and/or sexually abused. The number of treatment beds has declined, and we need to address the realities of this treatment gap. Currently, we are only treating 35 percent of the individuals in need of treatment. We also need to address quality-of-care issues.

There is some good news. There is more collaboration taking place among federal agencies, and Congress is reviewing treatment needs nationally. There continues to be a need for collaborative technical assistance. For example, in our case, we need to teach foster parents about the disease of addiction.

Catherine M. Nolan, M.S.W., A.C.S.W.

The Adoption and Safe Families Act (ASFA) was passed in 1997 and was the first major overhaul of child welfare legislation in approximately 20 years. This legislation also addresses some of the difficulties and tensions that we are here to discuss. There are several key elements of this legislation that are new.

ASFA states that the goals for children in the welfare system are permanency, safety, and well-being and provides great detail about why child safety is paramount. The legislation embodies the following key principles:

- **Child safety is the primary concern that must guide all child welfare services**. This contradicts previous legislation, which implied that the family must be unified at all costs. This remains a complex and contentious issue.

- **Foster care is a temporary setting and not the place for children to grow up.** Foster care was meant to be a temporary solution to child placement needs, yet children often languish in foster care settings. ASFA timelines require that if a child has been in foster care for 15 of the previous 22 months, the state must petition for termination of parental rights. This, too, remains a contentious issue.

- **Permanency planning for children should be initiated as soon as the child is placed in a foster care setting**. This issue exemplifies the need for the child welfare and substance abuse treatment systems to collaborate and highlights the complexity of the issue regarding access and timeliness of substance abuse treatment.

- **The child welfare system must focus on results and accountability**. This mandate is in response to legislative concern that some child welfare systems were in disarray. The Act requires the Department of Health and Human Services to work with states to establish performance indicators and to report data annually on how each state has met these indicators. The Act also requires an adoption incentive payment to states based on the increase in the number of adoptions for children in foster care. The goal is to double the number of permanent adoptions by 2002. States have responded positively to this incentive.

- **States should be given credit for innovative ideas on how to improve the child welfare system**. Delaware was the first state to receive a child welfare demonstration waiver from ACYF. Delaware proposed to assign a substance abuse worker to the child protective services teams to respond to substance abuse issues. This demonstration is now in its fifth year, and we eagerly await an evaluation of the program.

Landmark legislation such as ASFA requires that regulations be written and adopted. Our Children's Bureau Policy Division worked for several years writing the implementing regulations and putting them out for comment. They were published in the *National Register* on January 25, 2000. The regulations require a review process whereby 17 states will be visited by a review team annually. These review teams will assess how each state is complying with the goals of permanency, safety, and well-being. This process is being conducted in partnership with the states and will focus on program improvement.

Values Clarification: Building Toward a Joint Mission

Nancy K. Young, Ph.D., Director
Children and Family Futures
Irvine, CA

Fifty-one meeting participants responded to a pre-workshop questionnaire called the Collaborative Values Inventory. The survey was designed to help the child welfare and substance abuse treatment systems 1) clarify the underlying values in collaborative work; 2) develop common principles and goals; and 3) uncover differences in values that may impede cross-system collaboration. Often, differences in basic values and beliefs are the cause of the problem when even seemingly successful collaborations hit a roadblock. These differences can't be dismissed; they must be identified and discussed.

The survey provides state teams the opportunity to begin a discussion about some key questions, including: 1) What do we believe together? and 2) What don't we agree on? It also allows them to compare their individual state responses to the regional responses as a whole.

Individuals who completed the survey represent alcohol and other drug services (20); children's services (12); dependency/family court personnel (9); Medicaid providers (3); and others (7). There was strong agreement among these respondents in some areas.

For example, 49 of 51 respondents agreed that solving the problems caused by alcohol and other drug use would improve the lives of a significant number of children, families, and others in need. A majority of respondents (38) also agreed that alcohol and other drug providers should prioritize women from the child welfare system as their most important clients to receive services.

However, some interesting differences emerged, which can help pinpoint important areas states need to discuss. For example, there was little agreement among respondents about the statement that "illegal drugs are a bigger problem in our state than use and abuse of alcohol." Seventy percent of alcohol and other drug providers disagreed with the statement, while child welfare and court respondents were divided in their opinion. This is an important issue. Do we treat parents who have methamphetamine problems the same as we treat persons with alcohol problems? Are there clinical issues and child and family risk issues that are different for different substances?

Other areas without clear agreement include whether or not a parent who abuses alcohol or other drugs can be an effective parent. Alcohol and other drug providers disagreed with the statement that "there is no way that a parent who abuses alcohol or other drugs can be an effective parent." However, nearly 70 percent of the child welfare and court respondents agreed with the statement.

The various systems also had divergent views on the usefulness of urine screens for determining a parent's readiness to retain or regain custody of his/her children (court respondents find them useful), and whether allowing more services to be delivered by for-profit agencies would improve the effectiveness of services. Though most respondents believe that services should *not* be delivered by for-profit agencies, court respondents were more likely to feel that for-profit agencies would be more accountable. A majority of respondents (33) agreed that requiring all clients, regardless of income, to make some kind of payment for services would improve the effectiveness of services.

Alcohol and drug and child welfare respondents, as well as those representing other systems, agreed with the statement that "the most important causes of the problems of children and families cannot be addressed by government; they need to addressed within the family and by non-governmental organizations such as churches, neighborhood organizations, and self-help groups." Only court respondents disagreed. We need to think about what actions have to be taken at the governmental level for this to happen.

Interestingly, alcohol and drug respondents did not agree that people in recovery from substance abuse are the most effective counselors to work with their peers, but child welfare respondents overwhelmingly agreed with this idea. This response is counter to conventional thinking. If there is disagreement among respondents, what impact might this have on program policy?

There is also little agreement among respondents on whether confidentiality of client records is the most important barrier that keeps alcohol and other drug providers and child welfare agencies from working together. More than 80 percent of alcohol and other drug providers disagreed that confidentiality is the key barrier, but child welfare respondents were evenly split on this issue. A majority of respondents in both systems believe that most parents will be successful in alcohol and drug treatment and in family services.

Using the survey results, states can work together to discover what issues are important to them and how those issues play out in the ways they work together. Finally, they can ground these principles in reality by relating them to the three primary daily practice activities that take place between the two systems: 1) intake, screening and assessment; 2) engagement and retention in care; and 3) the provision of services to children.

Family Courts: Assessing and Responding to Child and Family Needs

The Honorable William R. Byars, Jr.
Children's Law Office
University of South Carolina

In the past family courts were concerned with two components–legal services and social welfare services. We now view the system as having three components, much like a three-legged stool. The legs of the stool are legal services, social welfare services, and now substance abuse services.

Before the Adoption and Safe Families Act (ASFA) was enacted, we had 500,00 children in foster care, 100,00 of whom were not going to permanent homes. In addition, our child protection system had become, in effect, a parent protection system. When the child got hurt we did not treat the child, we treated the parent. In 40 percent of cases, according to national statistics, the only service the child received was an assessment. We put our resources into treating the parents and put the children in foster care. They were raised there until they became juvenile delinquents. Then we spent *a lot* of money locking them up. That was the history of our system.

When I became a judge in South Carolina, I consulted with other judges about how they handled child welfare cases. They told me what they were told by the judges who were there when they came to the bench. There was a tendency to continue doing things the old way even in cases where the reasons for doing so were lost in time. I continued operating the way other judges told me to until I realized that the system was not working.

Children were not going back to their mothers; they were remaining in limbo. I also realized that a great many families who wanted to adopt children were going to other countries because we had our own children locked away. I felt that it was the fault of the child welfare system, which just needed to follow the directions of the court. When the Kellogg Foundation invited me to

Kalamazoo, MI, to discuss some new ideas in this area, I didn't realize the meeting would change my life.

I learned that in order to reform the system, we must first have a paradigm shift. I also observed the level of caring this community has for children. They not only took children into their homes, they took children into their families. They adopted kids. I saw a commitment, a "fire-in-the belly" that I envied.

I returned to South Carolina and started to think about a paradigm shift and how to apply it to real cases with real kids who have real problems. More specifically, how does a paradigm shift apply to the court room and how does it apply to abused and neglected kids? We have to view the child welfare system through a child's eyes. Let me give you an example. Think about time through a child's eyes. When a judge continues a case for 90 days, that may be considered a short period of time for the law, but it may seem like forever to a child who is not living at home. We view the system through the eyes of a judge, or a lawyer, or a social worker, but the correct way to view the system is through the eyes of a child.

Children also know fear and helplessness. Ninety percent of the cases we see have substance abuse behind them, and often the child doesn't know who is coming through the door or what aspect of that parent they will encounter. They often do not know who will be there or who will make decisions about their lives. These children really feel powerless and are full of fear.

For 20 years we knew that the South Carolina system was broken, but we didn't know how to fix it. We had been to the state legislature many times but nothing seemed to happen. Every time legislation would come up, members of each profession involved in the child welfare system would argue to change the bill to make it better for their profession. Nothing got done, and legislators were confused.

Several years ago we decided to meet to resolve this issue. The process required several months of meeting to take the system apart and put it back together. These meetings are not easy, but if the system needs to be changed, we have to include everyone. We can't have change without a unifying vision, and that vision must be through the eyes of a child.

What are some of the fact that we know about substance abuse? We know most prisoners in jail have a substance abuse problem and that 50 to 80 percent have been abused. We believe that most of the mothers who abuse kids have a substance abuse problem. Confidentiality regulations often become a barrier to treating mothers in the child welfare system and hurt the people that they were intended to protect. We must follow the law but also work to change it when it is not accomplishing its intent.

We know that children of parents who abuse substances are more likely to abuse substances themselves, so we must began treating children through prevention. We spend most of our monies on the perpetrators, and we must not leave the children out of the loop.

Alcohol and drug abuse professionals belong in the court room. They should not abrogate their responsibility to others to develop the treatment plans. We need to have someone who knows the system initiate the call to the treatment program. If we continue to do the same things, nothing will change. All three legs of the stool must be present.

It doesn't take more money to change the system, it takes passion. We need to convene meetings of like-minded persons and, above all, see things through the eyes of a child.

SUCCESSFUL APPROACHES/BEST PRACTICES

Connecticut: Retention of Women in Treatment

Peter Panzarella
Director of Substance Abuse Services
Connecticut Department of Children and Families

Project SAFE began in 1995 after three infant deaths in three months. Substance abuse was involved in each case, but the parents had not been screened. Project SAFE is a program for evaluation and treatment of alcohol and other drug dependency among parents in the child welfare system. The program is a collaboration among the State Department of Children and Families (DCF), the State Department of Mental Health and Addiction Services (DMHAS), and Advanced Behavioral Health (ABH), a network of nonprofit behavioral health providers.

Project SAFE services include a statewide centralized intake through a toll-free number. This gives DCF social workers priority access to ABH providers for drug screens, substance abuse evaluations, and a variety of outpatient substance abuse treatment services. The program also uses centralized data reports and electronic billing. The ABH provider network manages the quality of care.

As part of Phase I, Project SAFE staff created a specialized screening tool that includes information about both substance abuse and child welfare issues, and developed specific consent forms. DCF hired substance abuse specialists–licensed clinical social workers who are also certified alcoholism counselors–to serve as consultants, trainers, and provide some direct services to families.

The strengths of Phase I included: 1) a direct link between child welfare and substance abuse treatment; 2) priority access to substance abuse services for child welfare clients; 3) the simplicity of the system for child protective services workers; 4) the use of standardized clinical summaries and preferred practices; 5) a centralized data collection system; and 6) the development of DCF supportive housing for recovering families.

The limits of Phase I included: 1) limited collaboration between DCF and DMHAS, despite serving joint clients; 2) low rates of engagement and retention in treatment; 3) poor client

outcomes; 4) a behavioral health approach narrowly focused on addiction; and 5) different values and priorities between the two systems.

Phase II includes a focus on improved outcomes for women, children, and families. Focus groups of clients and providers indicated that success with this population is based on the following: 1) respect and empathy toward the client; 2) direct and clear communication: 3) ongoing motivation and engagement; and 4) good relationships among child protective services staff and substance abuse treatment providers. Nancy Young of Children and Family Futures helped the state develop a strategic plan for the DCF/DMHAS collaboration.

The Phase II Project SAFE program serves between 5,000 and 6,000 unduplicated clients a year. Eighty-four percent of these parents are referred by DCF social workers because of allegations of substance abuse in the child protective services report. Alcohol is the most significant problem substance for men (80 percent), and cocaine is the most significant problem substance for women (60 percent). Cocaine use by women in the child welfare system is disproportionately higher than it is in the adult treatment system as a whole.

Judith Ford
Director of Women's Behavioral Health and Trauma
Connecticut Department of Mental Health and Addiction Services

Most women served by Project SAFE are ages 18 to 35. Fifty percent are Caucasian, and the balance are African American and Latina. They are in low paying jobs, with many on welfare, and they have co-occurring trauma, depression, and other anxiety disorders. They also experience significant social stressors, including their involvement with child protective services, current violence, and homelessness or risk of homelessness.

All of these women are mothers, but that fact is not being addressed in substance abuse treatment. Our culture places a high value on the maternal role, and a mother is evaluated as a person by her success in this role. It is difficult for women to discuss their ambivalence about their roles as mothers. Most treatment programs stress a woman's role as a parent to provide for the physical needs of her children, and her very involvement in the child welfare system implies she has been a failure in this role. Fear of losing her children is a negative incentive. Few treatment programs address issues of emotional attachment and nurturing that allow a woman to discuss her feelings about her child and give her a positive incentive to stay in treatment.

To help women and their children heal, Project SAFE Phase II services include the following:

- **Outreach and engagement**. Outreach workers help women meet immediate survival needs and build on their strengths.
- **On-site child care**. Having their children with them makes mothers feel more comfortable, and it allows substance abuse treatment providers to see how families interact.

- **On-site parenting support**. On-site parenting groups provide mothers with education and support in the context of their substance abuse treatment.

- **Trauma education and treatment**. Trauma services include assessment, a three-session education model, and trauma-sensitive treatment.

- **Comprehensive substance abuse evaluations**. Project SAFE is field testing a family-focused substance abuse evaluation that includes a trauma screen, as well as information about anxiety and mental health and motivation to change.

Much of the hard work of coordination and collaboration takes place at the local level. Statewide, the Department of Mental Health and Addiction Services and the Department of Children and Families partnership is based on: 1) designated leadership and project responsibility; 2) joint program planning and evaluation; 3) regional service team meetings; 4) cross-training forums; 5) co-contracting; and 6) resource development and shared funding. The development of personal relationships and agreement on objectives also are key.

Wednesday, May 23

SUCCESSFUL APPROACHES/BEST PRACTICES

Illinois: Empowering Families through Collaboration

Maya Hennessey
Administrator of Women and Youth Services
Office of Alcoholism and Substance Abuse
Illinois Department of Human Services

Project SAFE is a collaborative effort between the Department of Children and Family Services (DCFS) and the Office of Alcoholism and Substance Abuse (OASA). Initially funded as a federal demonstration program, the program is now funded by the State of Illinois. The proof of Project SAFE's success is in the numbers: an 81 percent completion rate and a 54 percent reunification rate.

Parental addiction is an issue for 74 percent of Project SAFE clients, and nearly 100 percent have histories of domestic violence, including sexual abuse. Women show an early onset and long duration of violence, with multiple perpetrators and further victimization in a system that doesn't believe them. Most are single but in intimate, often abusive, relationships. They are dependent both on toxic relationships and on public institutions.

These women are difficult to engage, and they are at high risk for relapse, but acknowledgment of relapse is built into the program. It is not considered a measure of failure. As women progress through the program, their relapses are less intense and shorter in duration. Project SAFE also recognizes that women's alcoholism progresses differently than men's disease, a

factor important in assessment and treatment. For example, a man gives up on relationships in the early stages of alcoholism. But women cling to their relationships to the end, so they can be much further advanced in their disease and still have a connection to family and friends.

Project SAFE program components include the following:

- **Referrals**. All clients sign an initial consent form on referral that allows the substance abuse provider to acknowledge whether or not the client arrived for treatment. As more information is needed, the consent form is expanded incrementally.

- **Outreach**. Outreach is one of the keys to Project SAFE's success. Outreach workers befriend the mother and gain her trust. They meet immediate needs and help remove barriers to substance abuse treatment. They are seen as an ally, not an enemy. Each outreach worker is assigned 8 to 12 families.

- **Intensive outpatient treatment**. This includes 15 hours a week in group and individual treatment.

- **Transportation**. Initially viewed as an ancillary service, transportation has become an important assessment tool. Mothers and children are more open to sharing as they ride a van to appointments. Van transportation has become a sort of "traveling therapy group."

- **Child care**. Originally offered on-site, child care is now available at community sites and with friends and relatives. Once again, transportation to child care sites becomes an important time for outreach workers to see families interact.

- **Parenting**. Parenting education has to be introduced gradually, after staff gain the woman's trust. Project SAFE uses "experiential parenting," giving parents and children time to interact together so staff can observe a parent's behavior and correct it.

- **Case management/coordination**. Coordinating care for clients involved in multiple systems is time-consuming and complex. Case coordination takes place at weekly staff meetings and quarterly meetings.

- **Joint administration and evaluation**. DCYF and OASA conduct joint site visits and provide on-site technical assistance.

As the program has evolved, treatment has moved from a male-oriented model to a gender-sensitive, family-oriented model. Treatment is outcome-based, rather than time-based, and treatment plans are flexible and individualized. Using the American Society of Addiction Medicine (ASAM) criteria, clients are placed in appropriate treatment settings, which ensures better outcomes. Outpatients hours and services, as well as detox and residential hours and services, have been expanded.

Outcomes for various Project SAFE agencies vary, but commitment and shared responsibility and ownership are keys to success. Staff support is essential to prevent burnout. It's difficult to face this level of trauma and tragedy on a daily basis.

STATE TEAM REPORTS

One of the most important goals for this CSAT/ACYF workshop was to bring together state child welfare and substance abuse treatment systems to begin or continue collaborative efforts. Ms. Nolan asked state team representatives to consider three key questions as they met together during the two-day workshop. The questions and the state responses, as reported to the group as a whole, follow.

- Where were you at the start of the workshop as a state team?
- Where are you at the end of the workshop as a state team?
- Are there next steps planned?

Arkansas

The participants had some familiarity with each other, though some had not seen their colleagues for years. There was not, however, very much collaboration taking place. Team members believe they have a better understanding of the issues they face and, as a result, feel a bit overwhelmed. When they return to Arkansas, they know they have to get the "movers and shakers" to buy into their collaborative efforts to keep the momentum going.

Oklahoma

The Oklahoma team members feel they arrived at the workshop administratively segregated and somewhat naive. They are now aware of the need. They are poised to go back and pass on many of the concepts introduced to them at the workshop.

Louisiana

Prior to attending the workshop, the Louisiana substance abuse and child welfare agency staff met together. They conducted a joint survey to look at treatment needs and values. They also began developing a memorandum of understanding between their agencies to provide treatment services. Budget cuts and staff layoffs have severely slowed these efforts. They would like to pick up where they left off and continue their dialogue. They brainstormed ideas about cross-training and will make a request for technical assistance. They also plan to apply to SAMHSA for a grant to replicate the Illinois/Connecticut SAFE program.

Missouri

Missouri has some current collaborative efforts, including the Caring Communities Project, community coalitions, and other activities taking place between local agencies and state

agencies. They are called collaborations, but they happen in a vacuum. Activities are local, and information about them is not disseminated throughout the state. By attending the workshop, team members learned more about each other and have begun to form relationships. They will reconvene their group in several weeks to discuss the options for continuing their efforts and building this type of collaboration into the state system.

Nevada

Nevada has a lot of ongoing activities, but each has its own agenda, funding stream, and political motives. The state is moving closer to collaboration with placement of the substance abuse agency in the same department as the child welfare agency. Team members are writing RFPs that share funding, staff, training, and information. They also plan to develop collaborations with the legal system. They are trying to keep up with fast growth in Nevada and will reach out to other states and the federal government for help and technical assistance.

Iowa

The majority of Iowa's counties (88 of 91) have already been involved in a child welfare and substance abuse collaborative effort. The state substance abuse and child welfare agencies have been working closely to move this agenda forward. Though both child welfare and substance abuse personnel knew each other previously, this workshop provided an opportunity to develop relationships with their counterparts in the justice system and discuss how their systems need to work together. They hope to develop a similar working group when they return to Iowa that also includes juvenile court and district court judges.

Nebraska

Though there have been some collaborative efforts in Nebraska, they have been disjointed and dependent on individuals. The workshop has given team members a greater understanding of the system-wide implication of this issue and the powers that need to be at the table. The state has a new initiative called Families First, and team members will make sure they are involved in this effort. In addition, they will conduct joint planning to do cross-training. They will look to the federal government for help in that endeavor.

New Mexico

Like many states, New Mexico attempts to maximize federal dollars for the service delivery system. The result is a plethora of programs in both substance abuse and in child protective services that need fine-tuning and additional funding. Teams and coalitions are meeting separately throughout the state trying to develop drug courts and child welfare programs. Though these are not new issues, the workshop gave team members the opportunity to meet together and discuss strategies for improving the system. They will meet with all interested parties when they return home to try to combine different funding streams and put some programs in place.

Texas

In Texas, there is more of an appearance, rather than a reality, of collaboration at the state agency level. Team members have been engaged with the Texas Workforce Commission to do cross-training and service integration for substance abuse treatment and welfare-to-work. The state has asked CSAT for technical assistance to develop this effort around legal issues and best practices. The team recognizes the need to include the child welfare system in these training efforts. The state Department of Health plans to include child welfare and substance abuse treatment representatives in regional advisory groups for a perinatal service program it is developing.

Kansas

The Kansas state alcohol and drug agency and the child welfare agency representatives had never met until this workshop. The two agencies had planned to meet, and the workshop provided an opportunity to begin examining the issues involved in collaborative efforts. They plan to stay in touch with each other when they return home.

Arizona

Prior to 1998, the state was only contemplating change. Currently, Arizona has a number of seed projects, including expedited treatment for pregnant women with substance abuse disorders, a family recovery project, and a family drug court project. The state has also developed a program called Home Court Advantage, which is a collaboration with the National Center on Addiction and Substance Abuse to serve the needs of minority children who are overrepresented in the child welfare system. Arizona has theoretical models and plans that need to be put into action. Future challenges include training frontline workers to do family-centered treatment and providing substance abuse treatment to children and families who need it, regardless of where they enter the system.